Commonwealth Partnerships
for Antimicrobial Stewardship

Impact Report
Executive Summary

Scan for
full report

The Fleming Fund

UK International Development
Partnership | Progress | Prosperity

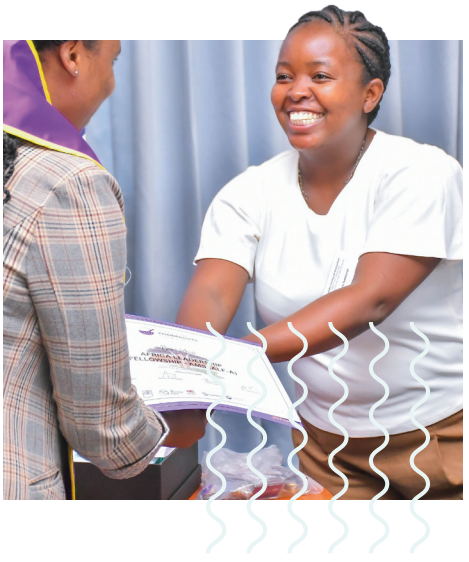
Global Health Partnerships
FORMERLY THET

COMMONWEALTH PHARMACISTS ASSOCIATION

Antimicrobial resistance remains one of the most serious threats to global health, and strong antimicrobial stewardship (AMS) together with effective infection prevention and control are essential to safeguarding the antibiotics we depend on.

I am deeply grateful to the Commonwealth Partnerships for Antimicrobial Stewardship programme for its leadership in strengthening AMS, building the global health workforce, and championing responsible antibiotic use.

Dame Sally Davies, UK Special Envoy on AMR



Introduction

Antimicrobial Resistance (AMR) is a major threat to global health security, disproportionately affecting low- and middle-income countries (LMICs) where infectious disease burdens are high and there is limited access to diagnostics and quality medicines.

In 2019, The Commonwealth Partnerships for Antimicrobial Stewardship (CwPAMS) programme, funded by the UK Department of Health and Social Care's Fleming Fund, and delivered by Global Health Partnerships (GHP – formerly THET) and the Commonwealth Pharmacists Association (CPA), set out to strengthen the health systems of eight Commonwealth countries in addressing AMR, while fostering meaningful cross-country learning.

The programme was grounded in the Health Partnership model, which links UK health institutions with counterparts in LMICs to co-develop sustainable solutions to priority health system challenges.

31 Health Partnerships were funded over the course of the programme to support over 200 health facilities across Ghana, Kenya, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda and Zambia.

Through volunteer engagement and institutional collaboration, UK and LMIC health professionals sought to address critical gaps in antimicrobial stewardship (AMS), infection prevention and control (IPC), and medicines optimisation.

The projects focused on capacity and leadership development, integrated process improvement, improved data collection and use, and pharmacist expertise and leadership.

Programme Description

Phase 1 ran from March 2019–June 2022 and supported 19 partnerships.

Projects focused on three core thematic areas: AMS and surveillance, antimicrobial pharmacy expertise, and IPC. The capacity development of health workers was a core focus, as well the building of improved data processes, and the collection of baseline data.

Building on these achievements, Phase 2 which ran from 2022–2025 expanded the programme's reach and strengthened the balance of AMR knowledge exchange between the UK and participating African Commonwealth countries, while further improving data collection and analysis to inform AMS interventions.

Learnings from Phase 1 led to the development of technical workstreams and inputs led by CPA which focused on:

Improving microbiology laboratory integration

Supporting facilities to embed microbiology into routine AMS practices, promoting the use of local diagnostic data for clinical decision-making and prescription, and enhancing communication between laboratories and clinical teams.

Strengthening the detection and reporting of substandard and falsified medicines

Developing learning material and webinars to strengthen understanding of detection and reporting mechanisms, and empowering pharmacists with the skills, confidence, and support needed to translate awareness into sustained institutional and community-level action.

Extending engagement into community pharmacy settings

Extending support for stewardship efforts to the frontline of medicine access, where community pharmacies, health workers, veterinary practitioners, and the public play a critical role in how antimicrobials are used.

Facilitating Global Health Leadership Fellowships

A structured fellowship model that moved beyond traditional overseas placements to foster co-leadership, peer learning and joint problem-solving between UK and African pharmacist fellows, strengthening quality improvement skills, cultural competence, communication and leadership.

Key approaches also shaped the programme during Phase 2:

The Hub and Spoke model

Advancing sustainability and extending programme reach by supporting LMIC institutions to become centres of excellence responsible for structured knowledge transfer, mentorship, and technical guidance to additional facilities.

One Health

Supporting Partnerships to consider human health as linked to animal and wider environmental health, and how this wider context affects AMR.

Gender Equality and Social Inclusion (GESI)

Supporting Partnerships to develop objectives to advance gender quality and social inclusion in their work, considering power dynamics and the inclusion of marginalised perspectives.

Global Health Partnerships supported grants management and provided technical expertise to embed GESI principles, while strengthening coordination and collaboration across health systems and stakeholders.

Outcomes

CwPAMS has achieved significant outcomes, including improved AMS and IPC knowledge and practice among health workers along with the widespread adoption of standardised tools and guidance to support effective AMR interventions.

There has also been enhanced leadership capacity and global AMR awareness amongst NHS staff.

Data Informing Interventions

Over the course of CwPAMS, participating institutions underwent a shift to improved generation of data on antimicrobial use to drive improvements in clinical practice.

Partners shifted from data collection to "Data for Action": strengthening data analysis, discussion, dissemination and decision-making and embedding quality improvement and behaviour change principles to ensure sustained impact.

In parallel, Health Partnerships worked to improve access to quality microbiology testing and more reliable microbiology data, allowing clinicians to make better and more targeted prescribing decisions based on the identification of specific pathogens.

Where laboratory capacity existed, facilities were enabled to produce antibiograms – a report used to identify specific causes of infection and the best antimicrobials to treat them – for the first time, translating sensitivity data into clear empiric prescribing guidance.

This shift has strengthened accountability, informed policy engagement, and positioned Heath Partnerships to sustain data-driven stewardship across the network.

Improved Structures, Knowledge and Processes

Across the programme, Partnerships worked to rehabilitate or establish AMS committees in nearly 90 health institutions.

These Committees formulated action plans which enabled a transition beyond basic awareness raising to competency development and workforce capability building at scale.

They have driven the delivery of new tools to support AMS and IPC, promoted uptake of microbiology services, promoted quality improvement, facilitated behaviour change and GESI, and promoted clinician (especially pharmacist) leadership.

Significant system-wide capacity building has taken place.

Across over 200 intervention sites, almost 35,000 health workers have received training, and a train-the-trainer model was employed to ensure sustained, cascaded training at intervention sites.

Educational resources have also been produced, improving pre-service curricula and CPD. There has also been widespread adoption of standardised tools and guidance to support effective AMR interventions.

Enhanced education and structures have been shown to produce greater guideline adherence, and innovations in AMS practice such as dedicated ward rounds and prescribing audits.

Other Key Outcomes

National and Regional policy influence, including the elevation of facility-level AMR policies to regional of national status (e.g. in Kenya), informing national action plans (Malawi), and influencing the development of a Parliamentary Forum on AMR (Uganda).

Advancement of the implementation of national AMR action plans.

Enhanced leadership capacity, professional practice, job satisfaction, and global AMR awareness amongst NHS staff.

Increased professional recognition for pharmacists, and expanded pharmacist involvement in clinical wards and governance committees.

Increased confidence amongst healthcare workers to make evidence-based prescribing decisions.

Expanded use of digital prescribing tools.

Improved reporting of substandard and falsified medicines.

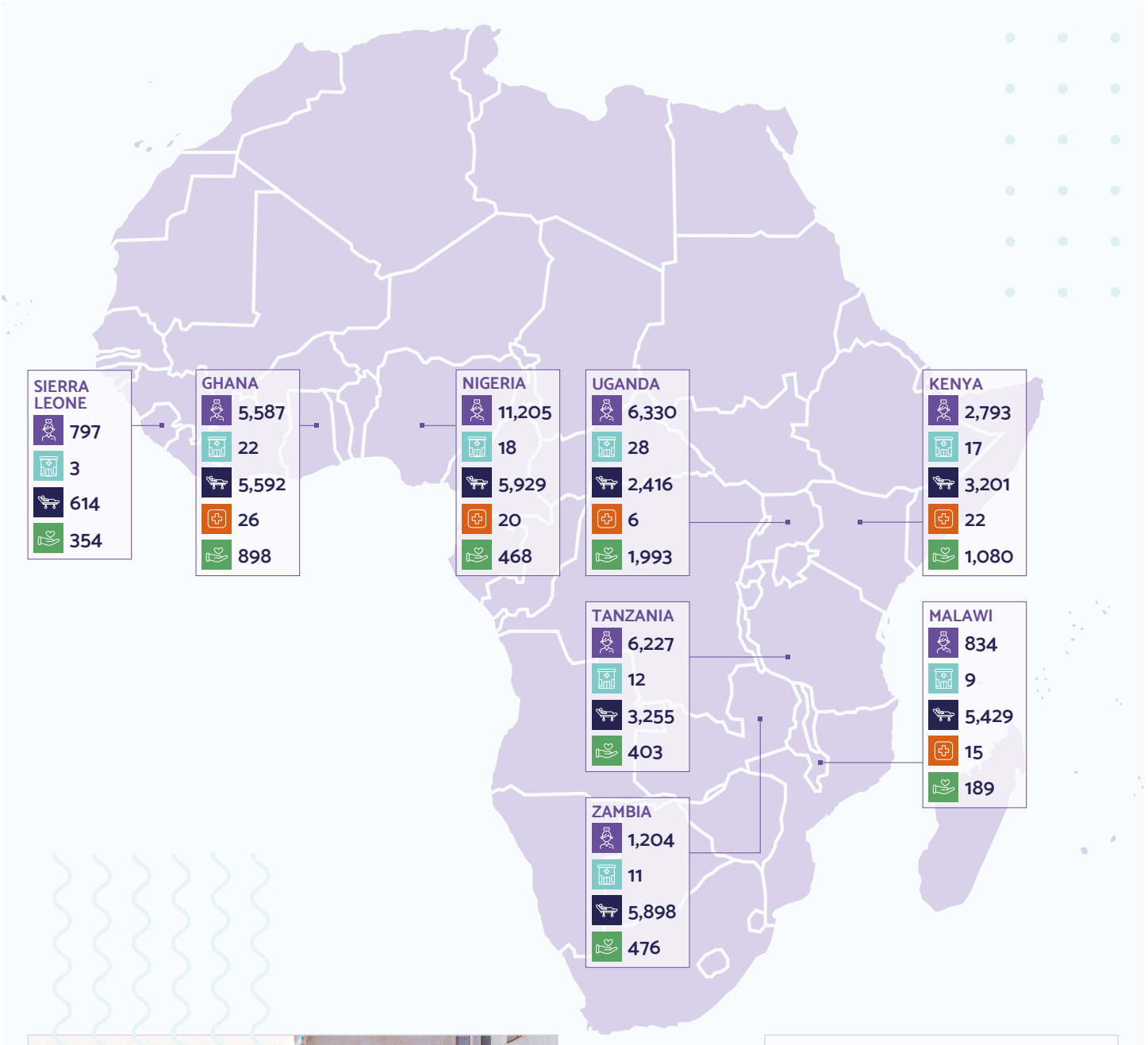
Strengthened economic cases for AMS investment.

Fig 1.

Key CwPAMS output and outcome data at the end of Phase 1 (2022) and at the end of Phase 2 (December 2025). Cumulative totals are shown.

Key outcome	Phase 1 (2022)	Phase 2 (2025)
No. of HPs supported	19	31
No. of Organisations involved (UK and LMIC)	84	265
No. of LMIC intervention sites	32	209
No. of Inpatient beds in supported LMIC intervention sites	8,738	32,334
No. of LMIC Health workers trained	6,544	34,977
No. of Volunteering days provided by UK Health Workers	2,164	5,861
No. of Global Health Leadership Fellowships completed	29	112
No. of Point Prevalence Surveys (PPS) undertaken in supported LMIC intervention sites	27	246
No. of Antibiograms completed in supported LMIC intervention sites	0	40

Programme Reach



KEY

- Healthcare Workers Trained
- Sites
- Inpatient Beds
- Community Pharmacies
- UK Volunteering Days

Sustainability

Sustainability has been woven into the programme from the outset.

The Health Partnership model works within existing health systems and structures, building capacity and leading process improvement, whilst ensuring that the focus of individual projects is led by strong local needs identification and ownership.

Certain technical areas were designed specifically to drive sustainability.

Leadership fellowships developed internal capacity for AMS leadership within health systems, while the Hub and Spoke model provides a platform for continued improvement at the facility level.

Several critical success factors have been identified which have helped CwPAMS drive sustainability:

Local Ownership
Facilities designed AMS action plans.

Institutionalisation
AMS Committees drive AMS activities that become part of routine activity.

Hub and Spoke Model
Decentralising and cascading mentorship and peer learning.

Leadership Engagement and National Alignment
Ownership from senior leaders and engagement with national reporting systems.

Data Systems that Inform Action
A shift in many facilities from reactive reporting to proactive clinical decision-making.

Workforce Development
Multi-professional training reducing dependency on specific individuals.

Strong Partnerships and Collaboration
Long standing partnerships that create bi-directional learning enabled technical exchange, problem solving, and co-design of interventions.

System-linked Alignment
A shift from individually-led activities to intentional linkage to facility, regional and national governance structures.

Value for Money
Efficiency and effectiveness driven by improvement of embedded systems, volunteering, and flexible use of funds.

CwPAMS has made significant progress in strengthening AMS governance, awareness, training and institutionalisation and in demonstrating a successful and adaptable model.

The Health Partnership model has advanced and embedded improved AMS and IPC processes, behaviours and outcomes in a locally owned, integrated, sustainable and mutually beneficial way.

And in so doing, it has improved the outlook on AMR and health security internationally.

Continued investment into scaling this impact and tackling the remaining system-level gaps and resource constraints will require AMR's prioritisation within national health agendas – not as separate AMR-focused plans – and an ongoing commitment to embedding it within governance, regulation and financing frameworks.

Commonwealth Partnerships for Antimicrobial Stewardship

Acknowledgements

GHP and CPA would like to express their sincere gratitude to all those who have enabled CwPAMS to achieve the successes set out in this report: The Change Exchange, Ducit Blue Solutions, UK and Partner Country institutions, and Health Partnerships who designed and led multiple interventions.

We would like to especially thank Ducit Blue Solutions who supported CwPAMS as coordination partner in Nigeria and grant management partner in Ghana.

We would also like to say a special thank you to the thousands of volunteers and health workers across the world whose dedication and expertise have made this programme possible.

CwPAMS was funded by the UK Department of Health and Social Care's Fleming Fund programme using UK aid.

The views expressed in this publication are those of the authors and not necessarily those of the UK Department of Health and Social Care.

Contact Details

GHP
Sophia Sachedina
Sophia.sachedina@globalhealthpartnerships.org

CPA
Helena Rosado
helena.rosado@commonwealthpharmacy.org

Published
March 2026

Global Health Partnerships
FORMERLY THET

COMMONWEALTH PHARMACISTS ASSOCIATION